VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086

Agency of Human Services

Limited Orthodontic Treatment Prior Authorization Request Form

(Effective 08/01/07)

(Please Print or Type)

1. Patient Information:

Patient Name: _____

Date of Birth: _____ Age: _____

Address: _____

Parent(s) Name: _____

Patient Medicaid I.D. Number: _____

Referring Dentist: _____

Preventive and restorative treatment completed to date: ☐ Yes ☐ No

Oral Hygiene: ☐ Good ☐ Fair ☐ Poor

2. Diagnosis:

Dentition: ☐ Primary ☐ Transitional ☐ Adolescent ☐ Adult

Angle Class: ☐ I ☐ II ☐ III

Overbite: _____mm Overjet: _____mm Crowding: _____mm

3. Diagnostic Treatment Criteria (please check all that apply-do NOT check if criteria not met):

☐ 1 Ectopically erupted anterior tooth
☐ 1 Blocked cuspid, per arch (deficient by at least 1/3 of needed space)
☐ 3 Congenitally missing teeth, per arch (excluding third molars)
☐ Open bite 4+ teeth, per arch
☐ Crowding, per arch (8+mm)
☐ Anterior crossbite
☐ Posterior crossbite
☐ Traumatic deep bite impinging on palate
☐ Overjet 6+mm (measured from labial to labial)

*Eligibility for limited orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of 1 of the diagnostic treatment criteria.

(Continue on back)

4. Other Functional Impairment:

If the patient does not meet the above criteria, but has a functional impairment that is equal to or greater than the severity of a functional impairment resulting from meeting those criteria, please briefly describe below and attach detailed written documentation from your office: _____

_____

_____

_____

_____

5. Special Medical Consideration: (Written documentation from a medical provider or outside specialist is required if you complete this section)

Medical Condition Requiring Special Consideration: _____

6. Proposed Treatment: Limited Orthodontic Treatment (check one): ☐ D8010 ☐ D8020 ☐ D8030 ☐ D8040

☐ Upper Arch: ☐ Fixed ☐ Removable Appliance: _____

☐ Lower Arch: ☐ Fixed ☐ Removable Appliance: _____

7. Additional Information:

Estimated time: _____

Requested Fee: _____

Date Submitted: _____

Submitted by: _____

Medicaid Individual and Group Provider Number(s): _____

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgement.

Provider Signature: _____

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
Fax: (802) 879-5963